

### **BREAST HEALTH SOLUTIONS**



# Breast Surgery Physician Professional Payment

| CPT <sup>®1</sup> Code/<br>HCPCS <sup>2</sup> Code | Description   | Place-of-Service        | RVU³  | 2022 National Average<br>Medicare Rate⁴ |
|--|---|-------------------------|-------|---|
| 19301  | Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);   | Professional (Facility) | 19.74 | \$683.13                                |
| 19302  | Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy   |                         | 27.11 | \$938.17                                |
| 19316  | Mastopexy   | Professional (Facility) | 23.43 | \$810.82                                |
| 19318  | Reduction mammaplasty   | Professional (Facility) | 32.33 | \$1,118.82                              |
| 38500  | Biopsy or excision of lymph node(s); open, superficial  | Professional (Facility) | 7.61  | \$263.35                                |
| 38525  | Biopsy or excision of lymph node(s); open, deep axillary node(s)  | Professional (Facility) | 13.15 | \$455.07                                |
| 38900  | Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure) | Professional (Facility) | 4.08  | \$141.19                                |
| 76098  | Radiological examination, surgical specimen   | Professional (Facility) | 0.45  | \$15.57                                 |
| 19499  | Unlisted Procedure, breast  | Professional (Facility) | N/A   | Determined by contractors               |

### **Facility Payment**

| CPT®1 Code/<br>HCPCS2 Code | Description  | Place-of-Service | APC⁵ | Status<br>Indicator <sup>6</sup> | 2022 National<br>Average Medicare<br>Rate <sup>5</sup> |
|----------------------------|--|------------------|------|----------------------------------|--|
| 19301                      |  | Hospital         | 5091 | J1                               | \$3,225.00   |
|                            | Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);  | ASC              | NA   | A2                               | \$1,205.70   |
| 19302                      | Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy  | Hospital         | 5092 | J1                               | \$5,652.10   |
| 19302                      |  | ASC              | NA   | A2                               | \$2,308.67   |
| 19316                      | Mastopexy  | Hospital         | 5092 | J1                               | \$5,652.10   |
| 19310                      |  | ASC              | NA   | A2                               | \$2,308.67   |
| 19318                      | Reduction mammaplasty  | Hospital         | 5092 | J1                               | \$5,652.10   |
| 19310                      |  | ASC              | NA   | A2                               | \$2,308.67   |
| 38500                      | Biopsy or excision of lymph node(s); open, superficial   | Hospital         | 5091 | J1                               | \$3,225.00   |
| 30300                      |  | ASC              | NA   | A2                               | \$1,205.70   |
| 38525                      | Biopsy or excision of lymph node(s); open, deep axillary node(s)   | Hospital         | 5091 | J1                               | \$3,225.00   |
| 00020                      |  | ASC              | NA   | A2                               | \$1,205.70   |
| 38900                      | Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)  | Hospital         | NA   | N                                | Packaged   |
| 00000                      |  | ASC              | NA   | N1                               | Packaged   |
| 76098                      | Radiological examination, surgical specimen  | Hospital         | 5524 | Q2                               | \$493.48   |
| 70090                      |  | ASC              | NA   | N1                               | Packaged   |
| 19499                      | Unlisted procedure, Breast   | Hospital         | 5091 | J1                               | \$3,225.00   |
| 13433                      |  | ASC              | NA   | NA                               | NA   |
| C9728                      | Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), for other than the following sites (any approach): abdomen,pelvis, prostate, retroperitoneum, thorax, single or multiple | Hospital         | 5613 | S                                | \$1,289.67   |
| 03120                      |  | ASC              | NA   | J8                               | \$870.84   |
| A4648                      | Tissue marker, implantable, any type, each   | Hospital         | NA   | N                                | NA   |
| A4040                      |  | ASC              | NA   | NA                               | NA   |

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#### BREAST HEALTH SOLUTIONS



## **Breast Surgery**

#### Modifier Information<sup>1</sup>

| Modifier | Description   | Explanation   |  |
|----------|---|---|--|
| 26       | Professional component  | Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number                               |  |
| 59       | Distinct Procedural Service   | Under certain circumstances, it may be necessary to indicate that procedure or service was distinct or independent from other non-E/M services performed on the same day  |  |
| 76       | Repeat procedure or service by same physician or other qualified health care professional | It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. The circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: this modifier should not be appended to an E/M service |  |
| 77       | Repeat Procedure by Another<br>Physician or Other Qualified<br>Health Care Professional   | It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service   |  |
| XE*      | Separate Encounter  | A service that is distinct because it occurred during a separate encounter  |  |
| XP*      | Separate Practitioner   | A service that is distinct because it was performed by a different practitioner   |  |

<sup>\*</sup> Specific Modifiers for Distinct Procedural Services, CMS Transmittal 1422, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf

#### Status Indicator Information<sup>5</sup>

| Status Indicator  | OPPS Status Indicator  |
|-------------------|--|
| Т                 | Paid separately under OPPS but multiple procedure reduction applies  |
| N                 | Payment is packaged into payment for other services. Therefore, there is no separate APC payment   |
| J1                | Comprehensive APC paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with status indicator "F", "G", "H", "L" and "U" |
| Q1                | Payment is packaged if billed on the same claim as a HCPCS code assigned status indicator "S", "T", or "V"; otherwise payment is made through a separate APC payment                                   |
| Q2                | Q2 is packaged if on the same "claim" rather than date of service.   |
| S                 | Significant procedure paid as separate APC payment under OPPS. Multiple procedure reduction does not apply   |
| U                 | Brachytherapy sources paid as separate APC payment under OPPS  |
| Payment Indicator | ASC Payment Indicator  |
| A2                | Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight   |
| J8                | Device-intensive procedure; paid at adjusted rate  |
| N1                | Packaged service/item; no separate payment made  |

- 1. American Medical Association (AMA), 2022 Current Procedural Terminology (CPT), Professional Edition. CPT codes and descriptions only are copyright 2021 AMA. All rights reserved. The AMA assumes no liability for data contained herein. No fee schedules, basic units, relative or related listings are included in CPT. Applicable FARS/DFARS Restrictions Apply for Government Use.
- 2. Centers for Medicare & Medicaid Services (CMS), 2022 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
- 3. The 2022 physician relative value units (RVUs) are from the 2022 Physician Fee Schedule (PFS) Relative Value Files, file RVU22A, available from the CMS website at https://www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files
- 4. The national average 2022 Medicare rates to physicians shown are based on the 2022 conversion factor of \$34.6062 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2022 should be available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at https://www.cms.gov/apps/physician-fee-schedule/overview.aspx. Any payment rates listed may be subject to change without notice. Actual payment to a physician will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.
- 5. The national average 2022 Medicare rates and status indicators for the hospital outpatient setting are from the 2022 Hospital Outpatient Prospective Payment System (OPPS) Correction release, Addenda B, and D1 accessible at https://www.cms.gov/license/ama?file=/files/zip/2022-nfrm-opps-addenda.zip [cms.gov]. The national average 2022 Medicare rates and status indicators for the ambulatory surgical center setting are from the 2022 Ambulatory Surgical Center (ASC) Payment Correction release, Addenda AA, BB, and DD1, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11\_Addenda\_Updates. Any payment rates listed are Medicare national averages that may be subject to change without notice and do not reflect payment cuts due to sequestration. Actual payment to a hospital or ambulatory surgical center will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.

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